

COBRA - PERS Group Continuation Plan

Employee

Employee's Name _____

Social Security Number _____

Mailing Address _____

Qualifying Event

☐ Termination of employment

☐ Reduction in hours

Election

☐ I do not wish to enroll in a PERS group continuation plan.

☐ I elect to enroll in a PERS group continuation plan.

Signature _____

Date _____

**YOU MUST COMPLETE AND RETURN THIS ELECTION FORM TO YOUR
PERSONNEL OFFICE OR YOUR HEALTH BENEFITS OFFICER
WITHIN 60 DAYS OF THIS NOTICE.**

COBRA - PERS Group Continuation Plan

Ex-Spouse or Dependent

Employee's Name _____

Social Security Number _____

Ex-Spouse or Dependent's Name _____

Mailing Address _____

Qualifying Event

- ☐ Termination of employment
- ☐ Reduction in hours
- ☐ Divorce / Legal separation / Moves out of household
- ☐ Attains age 23 / Ceases to be a dependent

Election

- ☐ I do not wish to enroll in a PERS group continuation plan.
- ☐ I elect to enroll in a PERS group continuation plan.

Signature _____

Date _____

**YOU MUST COMPLETE AND RETURN THIS ELECTION FORM
WITHIN 60 DAYS OF THIS NOTICE TO:**

(Agency to fill in return address)